**900 KAR 10:010. Exchange participation requirements and certification of qualified health plans and qualified stand-alone dental plans.**

RELATES TO: KRS 194A.050(1), 42 U.S.C. 18022, 18031, 18042, 18054, 45 C.F.R. Parts 155, 156

STATUTORY AUTHORITY: KRS 194A.050(1)

NECESSITY, FUNCTION, AND CONFORMITY: The Cabinet for Health and Family Services, Kentucky Office of Health Benefit and Information Exchange, has responsibility to administer the state-based American Health Benefit Exchange. KRS 194A.050(1) requires the secretary of the cabinet to promulgate administrative regulations necessary to protect, develop, and maintain the health, personal dignity, integrity, and sufficiency of the individual citizens of the Commonwealth; to operate the programs and fulfill the responsibilities vested in the cabinet; and to implement programs mandated by federal law or to qualify for the receipt of federal funds. This administrative regulation establishes the policies and procedures relating to the certification of a qualified health plan or a qualified stand-alone dental plan to be offered on the Kentucky Health Benefit Exchange, pursuant to and in accordance with 42 U.S.C. 18031 and 45 C.F.R. Parts 155 and 156.

Section 1. Definitions. (1) "Accreditation" means an accrediting entity recognized by HHS has reviewed the local performance of the health insurer's health insurance plans and assigned a level of accreditation.

(2) "Actuarial value" is defined by 45 C.F.R. 156.20.

(3) "Affordable Care Act" or "ACA" means the Patient Protection and Affordable Care Act, Public Law 111-148, enacted March 23, 2010, as amended by the Health Care and Education Reconciliation Act, Public Law 111-152, enacted March 30, 2010.

(4) "Agent" is defined by KRS 304.9-020(1).

(5) "Annual open enrollment period" is defined by 45 C.F.R. 155.410(e).

(6) "Benefit year" means a calendar year for which a health plan provides coverage for health benefits.

(7) "Cancellation" is defined by 45 C.F.R. 155.430(e).

(8) "Catastrophic plan" means a health plan that is described in and meets the requirements of 45 C.F.R 156.155.

(9) "Certificate of authority" is defined by KRS 304.1-110(1).

(10) "Certification" means a determination by the Kentucky Office of Health Benefit and Information Exchange (KOHBIE) that a health plan or a stand-alone dental plan has met the requirements established in Sections 2 through 21 of this administrative regulation.

(11) "Child-only plan" means an individual health policy that meets the requirements of 45 C.F.R. 156.200(c)(2) and provides coverage:

(a) To an individual under twenty-one (21) years of age; or

(b) That does not restrict the age of the primary subscriber to an individual over age twenty-one (21).

(12) "Consumer operated and oriented plan" or "CO-OP" is defined by 45 C.F.R. 156.505.

(13) "Cost-sharing reduction" or "CSR" means a reduction in cost sharing for:

(a) An eligible individual enrolled in a silver level plan in an individual exchange; or

(b) An individual who is an Indian enrolled in a qualified health plan in an individual exchange.

(14) "Dental insurer" means an insurer defined by KRS 304.17C-010(4), which offers a stand-alone dental plan for dental services.

(15) "Department of Health and Human Services" or "HHS" means the U.S. Department of

Health and Human Services.

(16) "Department of Insurance" or "DOI" is defined by KRS 304.1-050(2).

(17) "Enrollee" means an eligible individual enrolled in a qualified health plan or qualified stand-alone dental plan.

(18) "Essential community provider" means either a:

(a) Provider defined by 45 C.F.R. 156.235(c) that is determined and approved by HHS as an essential community provider for the Commonwealth of Kentucky; or

(b) Regional community services program for mental health or individuals with an intellectual disability established pursuant to KRS 210.370 through KRS 210.480, operating in Kentucky, and licensed pursuant to 902 KAR 20:091.

(19) "Essential community provider category" means a provider as described in 45 C.F.R. 156.235(a)(2)(ii)(B).

(20) "Essential health benefits" or "EHB" means the essential health benefits package referenced in 45 C.F.R. 156.20 and approved by the Secretary of HHS for the Commonwealth of Kentucky.

(21) "Health plan" is defined by 42 U.S.C. 18021(b)(1).

(22) "Health plan form" or "form" means an application, policy, certificate, contract, rider, endorsement, provider agreement, or risk sharing arrangement filed in accordance with 806 KAR 14:007.

(23) "Indian" is defined by 25 U.S.C. 450b(d).

(24) "Individual exchange" means the Kentucky Health Benefit Exchange that serves the individual health insurance market.

(25) "Individual market" is defined by KRS 304.17A-005(26).

(26) "Issuer" is defined by 45 C.F.R. 144.103.

(27) "Kentucky Health Benefit Exchange" or "KHBE" means the Kentucky state-based exchange approved by HHS pursuant to 45 C.F.R. 155.105 to offer a QHP or SADP that includes an:

(a) Individual exchange; and

(b) SHOP.

(28) "Kentucky Office of Health Benefit and Information Exchange", "KOHBIE", or "office" means the office created to administer the Kentucky Health Benefit Exchange.

(29) "Market segment" means either small group or individual market.

(30) "Metal level of coverage" means health care coverage provided within plus or minus two (2) percentage points of the full actuarial value as follows:

(a) Bronze level with an actuarial value of sixty (60) percent;

(b) Silver level with an actuarial value of seventy (70) percent;

(c) Gold level with an actuarial value of eighty (80) percent; and

(d) Platinum level with an actuarial value of ninety (90) percent.

(31) "Multi-state plan" means a health plan that is offered under a contract with the U.S. Office of Personnel Management in accordance with Section 1334 of the Affordable Care Act, 42 U.S.C. 18054.

(32) "Participating agent" means an agent who has been certified by the office to participate on the KHBE.

(33) "Participation agreement" means an agreement between the office and the issuer to offer a QHP or qualified stand-alone dental plan on the KHBE.

(34) "Pediatric dental essential health benefit" means a dental service to prevent disease and promote oral health, restore an oral structure to health and function, and treat an emergency condition provided to an individual under the age of twenty-one (21) years that meets the requirements of 45 C.F.R. 156.110(a)(10) and includes the benefits specified in 907 KAR

1:026.

(35) "Plan management data template" means the data collection templates used to facilitate data submission through SERFF for certification of qualified health plan issuers, qualified health plans, qualified stand-alone dental plan issuers, and qualified stand-alone dental plans as established in CMS Form Number CMS-10433, as amended.

(36) "Plan year" means a consecutive twelve (12) month period during which a health plan provides coverage for health benefits.

(37) "Premium" is defined by KRS 304.14-030.

(38) "Provider network" is defined by KRS 304.17A-005(35).

(39) "Qualified employee" means an individual employed by a qualified employer who has been offered health insurance coverage by the qualified employer through the SHOP.

(40) "Qualified employer" means an employer that elects to make, at a minimum, all full-time employees of the employer eligible for one (1) or more QHPs in the small group market offered through the SHOP.

(41) "Qualified health plan" or "QHP" means a health plan that meets the standards described in 45 C.F.R. 156 Subpart C and that has in effect a certification issued by the office.

(42) "Qualified individual" means an individual who has been determined eligible to enroll through the KHBE in a QHP or SADP in the individual market.

(43) "Service area" means a geographical area in which an issuer may offer a QHP.

(44) "SHOP" means a Small Business Health Options Program operated by the KHBE through which a qualified employer can provide a qualified employee and their dependents with access to one (1) or more QHPs.

(45) "Small group" is defined by KRS 304.17A-005(42) until superseded by 45 C.F.R. 155.20.

(46) "Spending account fact sheet" means a document that provides details about a health spending account, flexible spending account, or a health reimbursement account arrangement offered by the issuer as part of the benefits in a QHP.

(47) "Stand-alone dental plan" or "SADP" means a dental plan as described by 45 C.F.R. 155.1065 that has been certified by the office to provide a limited scope of dental benefits as defined in 26 U.S.C. 9832(c)(2)(A), including a pediatric dental essential health benefit.

(48) "Statement of dental coverage" means a written statement for providing information to consumers about an SADP’s coverage, benefits, and cost-sharing.

(49) "Summary of Benefits and Coverage" or "SBC" means a standard format, which complies with the requirements of 45 C.F.R. 147.200, created in accordance with 42 U.S.C. 300gg-15, for providing information to consumers about a health plan’s coverage and benefits.

(50) "System for Electronic Rate and Form Filing" or "SERFF" means an online system established and maintained by the National Association of Insurance Commissioners (NAIC) that enables an issuer to send and a state to receive, comment on, and approve or reject rate and form filings.

(51) "Termination" is defined by 45 C.F.R. 155.430(e).

Section 2. QHP Issuer General Requirements. In order for an issuer to participate in the KHBE, the issuer shall:

(1) Hold a certificate of authority and be in good standing with the Kentucky Department of Insurance;

(2) Be authorized by the office to participate on the KHBE;

(3) For the first year of participation in a new market segment, by April 1, submit Form KHBE-C1, Issuer Participation Intent Form, a nonbinding notice of intent to participate in the exchange during the next calendar year;

(4) Enter into a participation agreement with the office;

(5) Offer KHBE certified QHPs in the individual exchange or the SHOP exchange;

(6) Comply with benefit design standards as established in 45 C.F.R. 156.20;

(7) Provide coverage of the:

(a) Essential health benefits; or

(b) If the stand-alone pediatric dental essential health benefit is offered in the KHBE in each county within Kentucky in accordance with 45 C.F.R 155.1065, essential health benefits excluding pediatric dental essential health benefits;

(8)(a) Submit to the office a quality improvement strategy plan in compliance with 45 C.F.R. 156.200(b)(5) and 45 C.F.R. 156.1130;

(b) In the initial QHP certification process, submit an attestation to the office that the issuer shall comply with the quality requirements identified in 45 C.F.R. 156.200(b)(5) including:

1. Collection, disclosure, and report of information related to health care quality and outcomes in year two (2) of offering QHPs on the KHBE and annually thereafter; and

2. Implementation of an enrollee satisfaction survey in year two (2) of offering QHPs on the KHBE and annually thereafter;

(9) Comply with applicable standards described in 45 C.F.R. Part 153;

(10) For the individual exchange, offer at least a:

(a) QHP with a silver metal level of coverage;

(b) QHP with a gold metal level of coverage;

(c) Child-only plan; and

(d) Catastrophic plan;

(11) For the SHOP exchange, offer at least a:

(a) QHP with a silver metal level of coverage; and

(b) QHP with a gold metal level of coverage;

(12) Offer no more than eight (8) QHPs within a specified metal level of coverage within a market segment. For the purposes of establishing the number of QHPs offered in a metal level, the office shall consider the same plan:

(a) Offered with dental benefits and offered without dental benefits as one (1) QHP; or

(b) Limited to the essential health benefits and offering benefits in excess of the essential health benefits as one (1) QHP;

(13) Not discriminate, with respect to a QHP, on the basis of race, color, national origin, disability, age, sex, gender identity, or sexual orientation;

(14) Assure that the non-discrimination requirements in 42 U.S.C. 300gg-5 are met;

(15) If participating in the small group market, comply with KHBE processes, procedures, and requirements established in accordance with 42 C.F.R. 155.705 for the small group market and in accordance with 900 KAR 10:020;

(16) Allow a registered participating agent to enroll qualified individuals, qualified employers, and qualified employees on KHBE in accordance with the requirements of 900 KAR 10:050;

(17)(a) Offer a QHP in a statewide service area, except as allowed under paragraph (b) of this subsection; or

(b) Offer a QHP in a service area less than statewide if:

1. A QHP is available statewide;

2. The issuer’s service area includes one (1) or more counties;

3. The issuer’s service area is approved by the DOI; and

4. The issuer’s service area is established in a nondiscriminatory manner without regard to:

a. Race;

b. Ethnicity;

c. Language;

d. Health status of an individual in a service area; or

e. A factor that excludes a high utilizing, high cost, or medically-underserved population;

(18) Comply with the requirements of KRS Chapter 304;

(19) Submit form KHBE-C2, Kentucky Health Benefit Exchange Attestations; and

(20) Have the option, beginning in plan year 2017, to offer QHPs to include benefits in excess of the essential health benefits if the issuer also offers a corresponding QHP on the exchange at the same metal level that is limited to the essential health benefits.

Section 3. QHP Rate and Benefit Information. (1) A QHP issuer shall:

(a) Comply with the provisions of 45 C.F.R. 156.210 and KRS 304.17A-095(4);

(b) Submit to DOI through the SERFF system:

1. Form filings in compliance with KRS 304.14-120 and applicable administrative regulations promulgated thereunder;

2. Rate filings in compliance with KRS 304.17A-095 and applicable administrative regulations promulgated thereunder; and

3. Plan management data templates;

(c) Receive approval from DOI for a rate filing prior to implementation of the approved rate; and

(d) For a rate increase, post the justification prominently on the QHP issuer's Web site.

(2) A CO-OP, multi-state plan, and qualified stand-alone dental plan shall comply with the requirements established in subsection (1) of this section.

Section 4. QHP Certification Timeframes. (1) The office shall take final action on the request for certification no later than twenty-five (25) calendar days prior to the start of the annual open enrollment period for the following plan year.

(2) A QHP not certified by twenty-five (25) calendar days prior to the start of the annual open enrollment period shall not be offered on the exchange at any time during the following calendar year.

Section 5. Transparency in Coverage. (1) A QHP issuer shall provide the following information to the office in accordance with the standards established by subsection (2) of this section:

(a) Data as identified in 45 C.F.R. 155.1050(a) and 156.220;

(b) SBC written in English for each cost sharing reduction level in a QHP with the exception of zero cost sharing level for an Indian;

(c) SBC written in Spanish for each cost sharing reduction level in a QHP with the exception of zero cost sharing level for an Indian, with verification that the Spanish language version is a certified translation of the English version;

(d) If the plan includes a health reimbursement account, flexible spending account, or health savings account, a spending account fact sheet written in English for each cost sharing reduction level in a QHP consistent with the requirements in KRS 304.12-020 and 806 KAR 12:010;

(e) If the plan includes a health reimbursement account, flexible spending account, or health savings account, a spending account fact sheet written in Spanish for each cost sharing reduction level in a QHP with verification that the Spanish language version is a certified translation of the English version;

(f) Information on cost-sharing and payments for out-of-network coverage; and

(g) Information on enrollee rights under Title I of the Affordable Care Act.

(2) A QHP issuer shall:

(a) Submit, in an accurate and timely manner, to be determined by HHS, the information de-

scribed in subsection (1)(a), (f), and (g) of this section to the KHBE, HHS, and DOI;

(b) Provide public access to the information described in subsection (1) of this section;

(c) Provide the items described in subsection (1)(b) and (d) of this section to KHBE within five (5) calendar days of the date DOI has approved rate and form filings in SERFF; and

(d) Provide the items described in subsection (1)(c) and (e) of this section to KHBE within fourteen (14) calendar days of the date KHBE has approved the items described in paragraph (c) of this subsection.

(3) A QHP issuer shall ensure that the information submitted under subsection (1) of this section is provided in plain language as the term is defined by 45 C.F.R. 155.20.

(4)(a) A QHP issuer shall make available, in a timely manner, information about the amount of enrollee cost-sharing under the enrollee's plan or coverage relating to provision of a specific item or service by a participating provider upon the request of the enrollee.

(b) The information shall be made available to an enrollee through:

1. An Internet Web site; and

2. Other means if the enrollee does not have access to the Internet.

(5) A QHP issuer may provide the following information to KHBE in accordance with the standards established by subsection (2) of this section:

(a) SBC written in English for each zero cost sharing level for an Indian in a QHP; and

(b) SBC written in Spanish for each zero cost sharing level for an Indian in a QHP, with verification that the Spanish language version is a certified translation of the English version.

Section 6. Marketing and Benefit Design of QHPs. A QHP issuer and its officials, employees, agents, and representatives shall:

(1) Comply with issuer marketing practices provided under KRS Chapter 304.17A and 806 KAR 12:010; and

(2) Not employ marketing practices or benefit designs that will have the effect of discouraging the enrollment of individuals with complex health care needs in QHPs.

Section 7. Network Adequacy Standards. (1) A QHP issuer shall ensure that the provider network of a QHP:

(a) Is available to all enrollees within the QHP service area;

(b) Includes essential community providers in the QHP provider network in accordance with 45 C.F.R. 156.235 and meets the network adequacy standards for essential community providers as established in Section 8 of this administrative regulation;

(c) Maintains a network that is sufficient in number and types of providers, including providers that specialize in mental health and substance abuse services, to assure that all services will be provided in a timely manner;

(d) Meets the reasonable network adequacy provisions of 45 C.F.R. 156.230 and KRS 304.17A-515; and

(e) If not a managed care plan, meets the reasonable network adequacy provisions of 45 C.F.R. 156.230 and KRS 304.17A-515.

(2) A QHP issuer shall make its provider directory for a QHP available:

(a) To the KHBE for online publication;

(b) To potential enrollees in hard copy upon request; and

(c) In accordance with KRS 304.17A-590.

(3) A QHP issuer shall identify in the QHP provider directory a provider that is not accepting new patients.

Section 8. Network Adequacy Standards for Essential Community Providers. A QHP issuer

shall:

(1)(a) Demonstrate a provider network, which includes at least the minimum percent of available essential community providers in the QHP service area participate in the issuer's provider network as required by 45 C.F.R. 156.235(a)(2)(i); and

(b) Offer a contract to:

1. At least one (1) essential community provider in each essential community provider category in each county in the service area where an essential community provider in that category is available; and

2. Available Indian providers in the service area; or

(2) If unable to comply with the requirements in subsection (1) of this section, submit a supplementary response as identified in Supplementary Response: Inclusion of Essential Community Providers as incorporated by reference in this administrative regulation.

Section 9. Health Plan Applications and Notices. A QHP issuer shall provide an application, including the streamlined application designated by the office, and notices to enrollees pursuant to standards described in 45 C.F.R. 155.230.

Section 10. Consistency of Premium Rates Inside and Outside the KHBE for the Same QHP. A QHP issuer shall charge the same premium rate without regard to whether the plan is offered:

(1) Through the KHBE;

(2) By an issuer outside the KHBE; or

(3) Through a participating agent.

Section 11. Enrollment Periods for Qualified Individuals. (1) A QHP issuer participating in the individual market shall accept an enrollment during the open enrollment period or special enrollment period for a qualified individual participating in the individual market with effective dates of coverage established by the office in accordance with 45 C.F.R. 155.410(c)(1) and (f) and 45 C.F.R 155.420(b).

(2) A QHP issuer shall notify a qualified individual of the effective date of coverage.

(3) Premium invoices shall be generated to a qualified individual within five (5) business days from receipt of KHBE enrollment transactions.

(4) A QHP issuer shall allow a qualified individual a minimum of thirty (30) days from the date of the initial invoice to submit premium payment before coverage can be cancelled.

(5) A QHP issuer shall allow a qualified individual a minimum of thirty (30) days from the date of a corrected invoice to submit premium payment before coverage can be terminated.

(6) Notwithstanding the requirements of this section, coverage shall not be effective until premium payment is submitted by the individual.

(7) The issuer shall mail proof of coverage, including insurance identification cards, to enrollees within ten (10) calendar days of receipt of initial premium payment for ninety-nine (99) percent of enrollments.

Section 12. Enrollment Process for Qualified Individuals. (1) A QHP issuer shall process enrollment of an individual in accordance with this section.

(2) A QHP issuer participating in the individual market shall enroll a qualified individual if the KHBE:

(a) Notifies the QHP issuer that the individual is a qualified individual; and

(b) Transmits information to the QHP issuer in accordance with 45 C.F.R. 155.400(a).

(3) If an applicant initiates enrollment directly with the QHP issuer for enrollment in a plan of-

fered through the KHBE, the QHP issuer shall either:

(a) Direct the individual to file an application with the KHBE in accordance with 45 C.F.R. 155.310; or

(b) Ensure the applicant received an eligibility determination for coverage through the KHBE through the KHBE Internet Web site.

(4) A QHP issuer shall accept enrollment information in accordance with the privacy and security requirements established by the office pursuant to 45 C.F.R. 155.260 in an electronic format that meets the requirements established by the office pursuant to 45 C.F.R. 155.270.

(5) A QHP issuer shall follow the premium payment process established by the KHBE in accordance with 45 C.F.R. 155.240.

(6) A QHP issuer shall provide new enrollees with an enrollment information package that complies with the accessibility and readability requirements established by 45 C.F.R. 155.230(b).

(7) A QHP issuer shall reconcile enrollment files with the KHBE no less than once a month in accordance with 45 C.F.R. 155.400(d).

(8) A QHP issuer shall acknowledge receipt of enrollment information transmitted from the KHBE in accordance with KHBE requirements established by 45 C.F.R. 155.400(b)(2).

Section 13. Termination or Cancellation of Coverage for Qualified Individuals. (1) A QHP issuer may terminate coverage of an enrollee in accordance with 45 C.F.R. 155.430(b)(2).

(2) If an enrollee's coverage in a QHP is terminated by the issuer for any reason, the QHP issuer shall:

(a) Provide the enrollee with a notice of termination of coverage that includes the reason for termination at least thirty (30) days prior to the final day of coverage, in accordance with the effective date established pursuant to 45 C.F.R. 155.430(d);

(b) Notify the KHBE of the termination effective date and reason for termination; and

(c) Comply with the requirements of KRS 304.17A-240 to 304.17A-245.

(3) Termination of coverage of enrollees due to non-payment of premium in accordance with 45 C.F.R. 155.430(b)(2)(ii) shall:

(a) Include the grace period for enrollees receiving advance payments of the premium tax credits as described in 45 C.F.R. 156.270(d); and

(b) Be applied uniformly to enrollees in similar circumstances.

(4) Prior to termination of coverage, a QHP issuer shall provide a grace period of three (3) consecutive months if an enrollee receiving advance payments of the premium tax credit has previously paid at least one (1) full month's premium during the benefit year. During the grace period, the QHP issuer:

(a) 1. Shall pay claims for services provided to the enrollee in the first month of the grace period; and

2. May suspend payment of claims for services provided to the enrollee in the second and third months of the grace period;

(b) Shall notify the KHBE of the non-payment of the premium due; and

(c) Shall notify providers of the possibility for denied claims for services provided to an enrollee in the second and third months of the grace period.

(5) For the three (3) month grace period described in subsection (4) of this section, a QHP issuer shall:

(a) Continue to collect advance payments of the premium tax credit on behalf of the enrollee from the U.S. Department of the Treasury; and

(b) Return advance payments of the premium tax credit paid on behalf of the enrollee for the second and third months of the grace period if the enrollee exhausts the grace period as de-

scribed in subsection (7) of this section.

(6) If an enrollee is delinquent on premium payment, the QHP issuer shall provide the enrollee with a notice of the payment delinquency.

(7) If an enrollee receiving advance payments of the premium tax credit exhausts the three (3) month grace period in subsection (4) of this section without paying the outstanding premiums, the QHP issuer shall terminate the enrollee's coverage on the effective date of termination described in 45 C.F.R. 155.430(d)(4) if the QHP issuer meets the notice requirement specified in subsection (2) of this section.

(8) A QHP issuer shall maintain records in accordance with KHBE requirements established pursuant to 45 C.F.R. 155.430(c).

(9) A QHP issuer shall comply with the termination of coverage effective dates as described in 45 C.F.R. 155.430(d).

(10) A QHP issuer may cancel coverage of an enrollee in accordance with 45 C.F.R. 155.430(b)(2) and (e).

(11) If an enrollee's coverage in a QHP is cancelled by the issuer for any reason, the QHP issuer shall:

(a) Provide the enrollee with a notice of cancellation of coverage that includes the reason for cancellation within at least thirty (30) days of the action to cancel coverage, in accordance with the effective date established pursuant to 45 C.F.R. 155.430(d);

(b) Notify the KHBE of the cancellation effective date and reason for cancellation; and

(c) Comply with the requirements of KRS 304.17A-240 to 304.17A-245.

(12) Cancellation of coverage of enrollees due to non-payment of premium in accordance with 45 C.F.R. 155.430(b)(2)(ii) shall be applied uniformly to enrollees in similar circumstances.

(13) A QHP issuer shall comply with the cancellation of coverage effective dates as described in 45 C.F.R. 155.430(d).

(14) If coverage of an enrollee is terminated or cancelled by the KHBE for any reason, the QHP issuer shall provide the enrollee a notice of the termination or cancellation within fifteen (15) days of receipt of a termination or cancellation transaction from the KHBE.

Section 14. Accreditation of QHP Issuers. (1) A QHP issuer shall:

(a) Be accredited on the basis of local performance of a QHP by an accrediting entity recognized by HHS in categories identified by 45 C.F.R. 156.275(a)(1); and

(b) Pursuant to 45 C.F.R. 156.275(a)(2) authorize the accrediting entity that accredits the QHP issuer to release to the KHBE and HHS:

1. A copy of the most recent accreditation survey; and

2. Accreditation survey-related information that HHS may require, including corrective action plans and summaries of findings.

(2)(a) A QHP issuer shall be accredited prior to the fourth year of QHP certification and in every subsequent year of certification thereafter in accordance with the requirements and timeline identified under 45 C.F.R. 155.1045.

(b) A QHP issuer that has not received accreditation shall submit an attestation to the office that the issuer shall obtain accreditation in accordance with paragraph (a) of this subsection.

(3) The QHP issuer shall maintain accreditation so long as the QHP issuer offers QHPs.

Section 15. Decertification of QHPs. (1) If a QHP is decertified by the office pursuant to 45 C.F.R. 155.1080 or withdrawn by the issuer after certification, the QHP issuer shall terminate coverage of enrollees only after:

(a) The KHBE has provided notification as required by 45 C.F.R 155.1080(e);

(b) Enrollees have an opportunity to enroll in other coverage; and

(c) The QHP issuer has complied with the requirements of KRS 304.17A-240 to 304.17A-245, as applicable.

(2) If a QHP issuer fails to meet ongoing compliance requirements of Section 20 of this administrative regulation, the office may require the issuer to:

(a) Submit a corrective action plan to address deficiencies to ongoing compliance requirements within thirty (30) days of notification of the deficiency; and

(b) Submit evidence of compliance with the corrective action plan within the timeframes established in the office approved corrective plan.

(3) If the office finds that the QHP issuer failed to meet the requirements of subsection (2) of this section, the office may implement a prohibition against new enrollments on KHBE for the QHP issuer and market segment out of compliance or may decertify all plans offered by the QHP issuer within the market segment.

Section 16. General Requirements for a Stand-alone Dental Plan. (1) In order for a dental insurer to participate in the KHBE and offer a stand-alone dental plan, the dental insurer shall:

(a) Hold a certificate of authority that would permit the issuer to offer dental plans and be in good standing with the Kentucky Department of Insurance;

(b) Be authorized by the office to participate on the KHBE;

(c) For the first year of participation in a new market segment, by April 1, submit Form KHBE-C1, Issuer Participation Intent Form, a nonbinding notice of intent to participate in the exchange during the next calendar year;

(d) Enter into a participation agreement with the office;

(e) Offer a dental plan certified by the office in accordance with this administrative regulation in the individual exchange or SHOP exchange that shall:

1. Comply with the requirements of KRS Chapter 304 Subtitle 17C;

2. Submit to DOI through the SERFF system:

a. Form filings in compliance with KRS Chapter 304;

b. Rate filings in compliance with KRS 304.17-380; and

c. Dental plan management data templates;

(f) Offer a stand-alone dental plan that shall:

1. Provide the pediatric dental essential health benefits required by 42 U.S.C. 18022(b)(1)(J) for individuals up to twenty-one (21) years of age;

2. Pursuant to 45 C.F.R. 156.150, provide within a variation of plus or minus two (2) percentage points:

a. A low level of coverage with an actuarial value of seventy (70) percent; and

b. A high level of coverage with an actuarial value of eighty-five (85) percent; and

3. Have an annual limitation on cost-sharing for a stand-alone dental plan covering the pediatric dental EHB under 45 C.F.R. 155.1065 at or below:

a. $350 for a plan with one (1) child enrollee; or

b. $700 for a plan with two (2) or more child enrollees;

(g) Comply with the:

1. Provider network adequacy requirements identified by KRS 304.17C-040 and maintain a network that is sufficient in number and types of dental providers to assure that all dental services will be accessible without unreasonable delay in accordance with 45 C.F.R. 156.230;

2. Requirements for stand-alone dental plans referenced in 45 C.F.R. 156 Subpart E; and

3. Essential community provider requirements in 45 C.F.R. 156.235;

(h) Not discriminate, with respect to a pediatric dental plan, on the basis of race, color, national origin, disability, age, sex, gender identity, or sexual orientation; and

(i) Make its provider directory for a QHP available:

1. To the KHBE for online publication;

2. To potential enrollees in hard copy upon request; and

3. In accordance with KRS 304.17A-590.

(2) A dental insurer offering a stand-alone dental plan participating in the KHBE shall provide the following information to the office:

(a) Statement of dental coverage written in English consistent with the requirements in KRS 304.12-020 and 806 KAR 12:010;

(b) Statement of dental coverage written in Spanish with verification that the Spanish language version is a certified translation of the English version;

(c) The item described in paragraph (a) of this subsection within five (5) calendar days of the date DOI has approved rate and form filings in SERFF; and

(d) The item described in paragraph (b) of this subsection within fourteen (14) calendar days of the date KHBE has approved the items described in paragraph (a) of this subsection.

Section 17. Essential health benefits for individuals three (3) years of age and up to twenty-one (21) years of age. The KHBE shall ensure that an individual three (3) years of age and up to age twenty-one (21) years of age eligible to enroll in a QHP shall obtain coverage for pediatric dental coverage.

Section 18. Enforcement. The DOI shall be responsible for enforcing the requirements of KRS Chapter 304 and any administrative regulations promulgated thereunder against any issuer.

Section 19. Timeframes for Transactions. (1) A QHP issuer shall generate a required acknowledgement and process all KHBE initiated transactions within forty-eight (48) hours of receipt of a complete electronic transaction from the KHBE for ninety-five (95) percent of enrollments.

(2) A QHP issuer shall provide effectuation transactions to the KHBE within seventy-two (72) hours of receipt of the initial premium payment and issuer initiated cancellation and termination transactions within forty-eight (48) hours of the cancellation or termination of coverage for ninety-five (95) percent of cancellations and terminations.

Section 20. On-going Compliance. The office shall be responsible for enforcing the requirements referenced in 45 C.F.R. 155.1010(a)(2).

Section 21. Issuer Appeals. (1) An issuer may appeal the office’s decision to:

(a) Deny certification of a QHP;

(b) Implement a prohibition against new enrollments by a QHP issuer in a market segment; or

(c) Decertify a QHP.

(2) An issuer appeal identified in subsection (1) of this section shall be made to the office in accordance with KRS Chapter 13B.

Section 22. Incorporation by Reference. (1) The following material is incorporated by reference:

(a) "Form KHBE-C1, Issuer Participation Intent Form", May, 2015;

(b) "Form KHBE-C2, Kentucky Health Benefit Exchange Attestations", May, 2015; and

(c) "Supplementary Response: Inclusion of Essential Community Providers", May 2015.

(2) This material may be inspected, copied, or obtained, subject to applicable copyright law,

at the Kentucky Office of Health Benefit and Information Exchange, 12 Mill Creek Park, Frankfort, Kentucky 40601, Monday through Friday, 8 a.m. to 4:30 p.m., or from its Web site at www.healthbenefitexchange.ky.gov. (39 Ky.R. 2443; 40 Ky.R. 597; 1075; eff. 12-10-2013; 41 Ky.R. 2651; 42 Ky.R. 773; 1197; eff. 11-6-2015.)